110TH CONGRESS
2D SESSION

S. 3164

To amend title XVIII of the Social Security Act to reduce fraud under the Medicare program.

IN THE SENATE OF THE UNITED STATES

JUNE 19, 2008

Mr. MARTINEZ (for himself and Mr. CORNYN) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XVIII of the Social Security Act to reduce fraud under the Medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Seniors and Taxpayers Obligation Protection Act of 2008".

SEC. 2. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.

(a) PROCEDURES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used.

(2) MAINTAINING EXISTING HICN STRUCTURE.—In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD.—The procedures under paragraph (1) shall provide for a proc-

ess for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) PHASE-IN AUTHORITY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010 with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(b) EDUCATION AND OUTREACH.—The Secretary shall establish a program of education and outreach for individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and sup-

pliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 3. MONTHLY VERIFICATION OF ACCURACY OF CHARGES FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

"(7) The monthly verification of the accuracy of charges for physicians' services under the system under subsection (i).";

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence: "In the case of the activity described in subsection (b)(7), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is a medicare administrative contractor with a contract under section 1874A."; and

(3) by adding at the end the following new subsection:

"(i) MONTHLY VERIFICATION OF ACCURACY OF CHARGES FOR PHYSICIANS' SERVICES.—

"(1) SYSTEM.—

"(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary shall establish and implement a system to verify (electronically or otherwise, taking into consideration the administrative burden of such verification on physicians and group practices) on a monthly basis that the claims for reimbursement under part B for physicians' services furnished in high risk areas are—

"(i) for physicians' services actually furnished by the physician (or the physician's group practice); and

"(ii) otherwise accurate.

"(B) NO DETERMINATION OF MEDICAL NECESSITY.—In no case shall any verification conducted under the system established under subparagraph (A) include a determination of the medical necessity of the physicians' service.

"(2) VERIFICATION.—Under the system, the Secretary, at the end of each month, shall provide the physician (or the group practice) with a detailed

list of such claims for reimbursement that were submitted during the month in order for the physician (or the group practice) to review and verify the list. In providing the detailed list, the Secretary shall use the provider number of the physician (or the group practice).

"(3) AUDITS.—The Secretary shall conduct audits of the review and verification by physicians and group practices of the detailed list provided under paragraph (2). Such audits shall assess whether the physician or group practice conducted such review and verification in a fraudulent manner. In the case where the Secretary determines such review and verification was conducted in a fraudulent manner, the Secretary shall recoup any payments resulting from the fraudulent review and verification and impose a civil money penalty in an amount determined appropriate by the Secretary on the physician or group practice who conducted the fraudulent review and verification. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(4) HIGH RISK AREAS DEFINED.—In this subsection, the term 'high risk area' means a county designated as a high risk area under subsection (j)(1).

"(5) ACTIONS THROUGH MEDICARE ADMINISTRATIVE CONTRACTORS.—In carrying out this subsection, the Secretary shall act through medicare administrative contractors with a contract under section 1874A.

"(6) REPORT BY THE SECRETARY.—Not later than 1 year after implementation of the system established under paragraph (1), the Secretary shall submit a report to Congress on the progress of such implementation. Such report shall include recommendations—

"(A) on how to improve such implementation, including whether the system should be expanded to include verification of claims for reimbursement under part B for physicians' services furnished in additional areas; and

"(B) for such legislation and administrative action as the Secretary determines appropriate.".

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are au-

thorized to be appropriated such sums as may be necessary for each of fiscal years 2009 through 2013.

SEC. 4. DETECTION OF MEDICARE FRAUD IN HIGH RISK AREAS.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd), as amended by section 3, is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

"(8) Implementation of prepayment fraud detection methods under subsection (j).";

(2) in subsection (c), in the second sentence of the flush matter following paragraph (4), by striking "activity described in subsection (b)(7)" and inserting "activities described in paragraphs (7) and (8) of subsection (b)"; and

(3) by adding at the end the following new subsection:

"(j) DETECTION OF MEDICARE FRAUD IN HIGH RISK AREAS.—

"(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.—Not later than 6 months after the date of the enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to

fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary shall designate the counties identified under the preceding sentence as 'high risk areas'.

"(2) PREPAYMENT FRAUD DETECTION.—The Secretary shall establish procedures for the implementation of prepayment fraud detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1), including the following:

"(A) Pre-enrollment site visits for such providers of services and suppliers which have the highest probability of committing fraud under this title.

"(B) Data analysis to establish prepayment claim edits designed to target the claims for reimbursement under this title for such items and services that are most likely to be fraudulent.

"(C) Prepayment benefit integrity reviews for claims for reimbursement under this title

for such items and services that are suspended as a result of such edits.

"(3) ACTIONS THROUGH MEDICARE ADMINISTRATIVE CONTRACTORS.—In carrying out this subsection, the Secretary shall act through medicare administrative contractors with a contract under section 1874A.

"(4) REPORT TO CONGRESS.—The Secretary shall, upon request, appear and testify before Congress regarding the status of the implementation of prepayment fraud detection methods under this subsection.".

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2009 through 2013.

SEC. 5. STUDY ON THE USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

(a) STUDY ON THE USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.—The Secretary of Health and Human Services shall conduct a study on the use of technology (similar to that used with respect to the analysis of credit card charging patterns) to provide real-time data analysis of claims for reimbursement under the Medicare

program under title XVIII of the Social Security Act to identify and investigate unusual billing or order practices under the Medicare program that could indicate fraud or abuse. Such study shall include an analysis of the following:

(1) Whether such technology could be used to identify unusual billing or order practices under the Medicare program by an individual provider of services or for a certain HCPCS code in a particular area of the country without alerting potentially fraudulent providers of services and allowing them to escape or go unnoticed.

(2) How such technology can be implemented under the Medicare program to provide for the effective review of claim logs in an accurate and timely manner.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.

Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

"(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO REIMBURSEMENT.—

"(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for reimbursement for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

"(i) that the Medicare identification number of the supplier is active; and

"(ii) that the item or service for which the claim for reimbursement is submitted was properly identified on the CMS–855S Medicare enrollment application.

"(B) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar

to that used for the National Provider Identifier to enable providers of services, accreditors, carriers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS–855S Medicare enrollment application submitted by the supplier.

"(C) NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.—In the case where a claim for reimbursement for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

"(i) the National Supplier Clearinghouse shall—

"(I) provide the supplier written notification of the reason for such denial; and

"(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

"(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment under this title in order to permit the resubmission of such claim if payment of such claim would otherwise be allowed under this title.".

SEC. 7. SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), as amended by section 6(a), is amended by adding at the end the following new paragraph:

"(23) SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.—

"(A) ESTABLISHMENT.—In the case of any item of durable medical equipment which has not been issued a unique identifier under the unique device identification system established under section 519(f) of the Federal Food, Drug, and Cosmetic Act, the Secretary shall promulgate regulations establishing a system for such durable medical equipment requiring the label of such equipment to bear a unique identifier, unless the Secretary requires

an alternative placement or provides an exception for a particular item or type of durable medical equipment under such section 519(f).

"(B) PROVISION OF UNIQUE IDENTIFIER TO THE SECRETARY.—A manufacturer of an item of durable medical equipment shall submit to the Secretary the unique identifier issued under subparagraph (A) or such section 519(f) with respect to such item (in accordance with procedures established by the Secretary). The Secretary shall provide for the storage of such unique identifier in accordance with subparagraph (D)(i).

"(C) REQUIREMENTS FOR MANUFACTURERS AND WHOLESALERS.—A manufacturer of an item of durable medical equipment, or, in the case where a wholesaler provides an item of durable medical equipment to a supplier, the wholesaler, shall—

"(i) upon issuing an item to a supplier, develop a product description for the item which includes—

"(I) the unique identifier of the item;

"(II) the specific Healthcare Common Procedure Coding System (HCPCS) code for the item;

"(III) the name of the supplier the item was shipped to; and

"(IV) the supplier's Medicare identification number; and

"(ii) submit the product description developed under clause (i) to the Secretary for storage in the unique identifier database in accordance with subparagraph (E)(i).

"(D) REQUIREMENTS FOR SUPPLIERS.—A supplier of an item of durable medical equipment shall—

"(i) upon issuing the item to a beneficiary, note the unique identifier of such item on—

"(I) the claim form submitted for such item; and

"(II) when appropriate or otherwise required, the detailed product description of the item;

"(ii) in the case where the item is issued to a beneficiary on a rental basis,

designate the unique identifier with an 'R' after the number to indicate that the item was rented, and not purchased, by the beneficiary; and

"(iii) upon return of the item to the supplier, notify the Secretary—

"(I) before reissuing that item and resubmitting that number on such a claim form; or

"(II) upon resubmitting that number on such a claim form.

"(E) REQUIREMENTS FOR THE SECRETARY.—

"(i) MAINTENANCE OF DATABASE OF SERIAL NUMBERS.—The Secretary shall establish and maintain a database containing the unique identifiers submitted by manufacturers of items of durable medical equipment under subparagraph (B).

"(ii) PAYMENT.—

"(I) LIMITATION.—Subject to subclause (II), payment may only be made for an item of durable medical equipment under this part if the unique identifier on the claim form

submitted for such item matches the unique identifier submitted by the manufacturer of such item under subparagraph (B).

"(II) EXCEPTION TO LIMITATION AFTER VERIFICATION OF RECEIPT.—In the case where the unique identifier is not on the claim form submitted for such item or does not match the unique identifier submitted by the manufacturer of such item under subparagraph (B), no payment shall be made under this part for the item of durable medical equipment until the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

"(III) DUPLICATIVE UNIQUE IDENTIFIERS.—In the case where a unique identifier is submitted on more than 1 claim form submitted for such an item and there is no indication from the supplier that the item of durable medical equipment has been returned by 1 beneficiary and is now

being used by another beneficiary, no payment shall be made under this part for such item of durable medical equipment unless the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

"(IV) VERIFICATION.—The Secretary shall conduct any verification required under subclause (II) or (III) within 30 days after receipt by the Secretary of the relevant claim form. In the case where such verification is not completed within such time period, the Secretary shall pay such claim, complete the verification, and, in the case where the Secretary has entered into a contract with an entity for the conduct of such verification, recover any payments that would not have been made if the verification had been completed within such time period from such entity.

"(iii) QUALITY CONTROL AUDITS.—The Secretary shall conduct quality control

audits to identify unusual billing patterns with respect to items of durable medical equipment for which payment is made under this part and may conduct unannounced site visits or commission other agencies to conduct such site visits as part of such quality control audits.

"(iv) NO USE AS A PRECERTIFICATION MECHANISM.—In no case shall a unique identifier issued under subparagraph (A) or section 519(f) of the Federal Food, Drug, and Cosmetic Act be used as a precertification mechanism for the supply of an item of durable medical equipment or the payment of a claim for such an item under this part.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 3 years after the date of enactment of this Act.

SEC. 8. SENSE OF THE SENATE REGARDING SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.

(a) FINDINGS.—The Senate finds the following:

(1) Documented fraud in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Sup-

plies Competitive Bidding Program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) has potentially cost taxpayers in the United States billions of dollars.

(2) Congress, having previously recognized fraudulent practices with respect to durable medical equipment under the Medicare program under title XVIII of the Social Security Act, directed the Secretary of Health and Human Services to take action against such fraudulent practices through the implementation of a surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)), as added by section 4312 of the Balanced Budget Act of 1997 (Public Law 105–33).

(3) Such surety bond requirement is necessary to—

(A) limit the risk to the Medicare program of fraudulent suppliers of durable medical equipment;

(B) enhance the enrollment process under the Medicare program to ensure that only legitimate suppliers of durable medical equipment are enrolled or are allowed to remain enrolled in

any programs established or implemented under the Medicare program;

(C) ensure that the Medicare program recoups erroneous payments that result from fraudulent or abusive billing practices by allowing the Centers for Medicare & Medicaid Services, or entities under a contract with the Centers for Medicare & Medicaid Services, to seek payments from a surety up to the penal sum; and

(D) help ensure that beneficiaries under the Medicare program receive items and services that are considered reasonable and necessary from legitimate suppliers of durable medical equipment.

(4) To date, more than a decade after the enactment of the Balanced Budget Act of 1997 (Public Law 105–33), such section 1834(a)(16) has yet to be implemented by the Secretary of Health and Human Services, potentially costing taxpayers and Medicare beneficiaries billions of additional dollars and negatively impacting responsible suppliers of durable medical equipment under the Medicare program.

(b) SENSE OF THE SENATE.—It is the Sense of the Senate that the Secretary of Health and Human Services must put in place the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) within 6 months of the date of enactment of this Act in order to maintain integrity under the Medicare program.

○